

## **Pioneer Assurance Company Limited**

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# STRICTLY CONFIDENTIAL MEDICAL EXAMINATION REPORT

FULL NAME:	MARITAL STATUS
DATE OF BIRTH:	SEX
OCCUPATION:	
PAR	Τ1

a) Have you satisfied yourself with the id	lentity of the applicant?	YES NO	)	
b) Applicants identification:	ID CARD	PASSPORT	BIRTH CERT	DRIVING LICENCE
NUMBER				

# IF THE APPLICANT IS NOT ABLE TO PROVIDE SATISFACTORY IDENTIFICATION PLEASE DO NOT PROCEED

#### PART 2

The following questions are to be asked by the medical examiner and answered by the applicant.

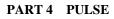
	ou ever suffered from any of the following	YES/NO	If answering 'yes' to any of the questions, please give full details including dates
1. a)	Bronchitis, Asthma or any other lung condition?		
b)	Anxiety, depression, nervous breakdown, or any other nervous		
	or mental disorder?		
c)	Angina, heart attack, hypertension, rheumatic fever, valve		
	problem, or any other heart disorder?		
d)	Stomach, bowel, liver or gallbladder disorder?		
e)	Attacks of arthritis or gout?		
f)	Diabetes, kidney, bladder or any other urinary disorder?		
g)	Enlarged glands, growths, tumors or cancers?		
I			

r					
	h)	Cerebellar vascular accident or neurological disorder?			
	i)	Any significant disease or injury not mentioned above?			
2.					
	a)	Have you ever undergone any surgical operations X-rays,			
		investigations or blood tests?			
	b)	Are you taking any form of drugs?			
	c)	Have you ever: received treatment for high blood pressure?			
3.					
	a)	Have you ever had an AIDS blood test?			
	b)	Have you ever received medical advice, counseling or treatment in connection with AIDS or any other sexually transmitted diseases including hepatitis B?			
4.					
	a)	Have you ever taken drugs other than for medical purposes?			
5.			Beer	Wine	Spirits
	a)	Do you consume alcohol? If so, how regularly and in what form		<u>.</u>	
	b)	Do you smoke? If so, how much and in what form	Cigarettes	Cigars	Tobacco
		n so, now much and in what form			

## PART 3 FAMILY HISTORY

FAMILY RELATIONSHIP	IF LIVING		IF DEAD	
	AGE	STATE OF HEALTH	AGE AT DEATH	CAUSE OF DEATH
FATHER				
MOTHER	1	•		
BROTHERS				
SISTERS	1			
a) Have any of the above ever had a heart disease, hemophilia, kidney disease, mental disorders or any hereditary condition?				
b) Is the heart enlarged?				
c) Is there any abnormal origin?	ity of the	heart sounds or murmurs p	resent? If murmur fou	nd, state whether functional or organic in

Signed in my presence at this day of 20	I certify that my answers to the foregoing questions and statements are correct and form part of my application for insurance. I hereby authorize any and every Doctor who has attended me, or may hereafter attend me, or whom I have consulted, or may hereafter consult, to disclose in evidence upon oath or in writing at any time and from time to time all information which he may in any manner
Medical Examiner	have acquired.
Full Name	
	Signature of Applicant
	(Applicant should be there in presence of Medical Examiner)



a)	Measure rate and describe character?
b)	What is the state of the arterial walls?
c)	Is there any vascular abnormality in the legs or reduced foot pulse?

## PART 5 BLOOD PRESSURE

If the first reading exceeds 140 systolic or 90 diastolic (5 th phase), please take 2 <sup>nd</sup> and 3 <sup>rd</sup> readings at 5minutes intervals			
	1 <sup>ST</sup> READING	2 <sup>ND</sup> READING	3 <sup>RD</sup> READING
Systolic			
Diastolic (4 th phase)			
Diastolic (5 th Phase)			
Pulse Rate			

#### PART 6 URINE

a)	Is albumen present?
b)	Is sugar present?

I declare the aforementioned statements are true to the best of my knowledge and belief and I agree that shall form part of my application for life assurance.

Examiner's signature

Date:

## PART 7 MEDICAL EXAMINATION

Answe	ers to be given	by doctor. Please give	e details where appropri-	ate	
-	SUREMENTS				
HEIGHT WEIGHT			EST	ABDOMEN	
			At full inspiration	At full Expiration	At the umbilicus
a)	Does the weight	t appear constant, increasi	ng or decreasing?	1	
	-				
b)	Describe the gar	neral build and appearance	<u>م</u>		
0)	Deserribe the ger	neral bund and appearance			
c)	Does the appear	ance correspond with the	stated age?		
d)	Is there any evid	lence of intemperate habit	s?		
	PIRATORY SYS	STEM developed and does it exp	pand fraaly?		
<i>a)</i>	is the chest well				
b)	Are there any no	ormal physical signs?			
3. HEA	RT				
a)	Is the position of	f the apex beat normal?			
b)	Is it unduly force	eful?			
- /	, in the second s				
	T. 1.1 1	0			
c)	Is blood present	?			
d)	Any other abnor	rmalities?			
4. ABD	OMEN				
a)		lence of past or present di	gestive trouble or disorder of	:	
,	<u> </u>		0		
	i) The Liver				
	ii) The Spleen?				
	· <u>1</u>				
	iii) The stomach				
	m) The stomach	1			
	Iv) The bowels				
b)	Is there hernia p	present?			
	15 there herma p				

VOUS SYSTEM
Are the pupil reactions normal?
Are the knee and ankle reflexes normal?
Are speech, memory and sight normal?
Is there evidence of an ear disorder or hearing impaired?
Is there evidence of any disease of the central nervous system?

#### ADDITIONAL INFORMATION

Please elaborate on any relevant answers given by the examinee and any abnormal findings where significant. Pease attach an additional sheet if necessary.

Medical examiner's full name and qualifications (BLOCK LETTERS PLEASE)

Signature

Full address to which fee will sent

Name:

Address:

Tel/Fax:

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